Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: BRUCE WHITEHEAD, M.D. P.O. BOX 741865 DALLAS, TX 75374	MFDR Tracking #:	m4-10-1936-01 (Formerly M4-08-5396-01)
Respondent Name and Box #: ACE FIRE INSURANCE UNDERWRITERS INS CO REP. BOX #: 15		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary as stated on the Table of Disputed Services: "Requested test for Designated Dr. exam. Does not count toward FCE maximum."

Principal Documentation:

lDWC 60 package

1. Total Amount Sought - $573.76
2. CMS 1500s
3. EOB

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: NO CARRIER RESPONSE

Principal Documentation:

1. NONE

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Part V Reference	Amount Ordered
04/19/2007	CPT Code 97750-FC ($28.69 x 125% = $35.86 x 16 units = $573.76	1 – 3	$573.76
Total:			$573.76

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and 28 Texas Administrative Code (TAC) Section 134.202, titled *Medical Fee Guideline* effective for professional medical services on or after August 1, 2003, set out the reimbursement guidelines.

1. Charges were denied with exception code 18-Duplicate claim/service (880-154) THE SUBMITTED CHARGE IS A DUPLICATE OF A PREVIOUSLY REVIEWED CHARGE 100% on the Explanation of Benefits. The Requestor sent a reconsideration billing disputing the review as no previous EOB had been received and has not received a response. Sufficient time has been allowed for Requestor to respond to reconsideration attempts on February 22, 2007 and again on June 08, 2007. In accordance with Rule 133.307(e)(2)(B), the Requestor submitted convincing evidence of the carrier's receipt of the Requestor's request for and EOB.

2. According to the submitted billing for CPT code 97750 FC for a Functional Capacity Evaluation (FCE), the claimant was referred to Diagnostic Imaging Institute, Inc. by the Designated Doctor Bruce Whitehead, MD. The FCE report documents the start time as 09:00 am and the end time as 1:00 pm. According to the CMS-1500, 16 units (4 hours) were billed. Therefore, per 28 TAC Section 134.202(e)(4) and 134.202(c) reimbursement is recommended.
3. Per review of Box 32 on CMS-1500, zip code 77401 is located in Harris County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 134.1, 133.307, 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $573.76 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature	Medical Fee Dispute Resolution	December 4, 2009 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.